Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005102	A. BUILDING _____ B. WING _____	11/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL HOSPITAL AND HEALTH CARE CENTER	800 W 9TH ST JASPER, IN 47546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for the investigation of one State complaint. Complaint # IN00096600 Unsubstantiated: Lack of sufficient evidence Facility #: 005102 Date: 11-15-11 Surveyor: Billie Jo Fritch RN, BSN, MBA Public Health Nurse Surveyor Memorial Hospital and Health Care Center is in compliance with 410 IAC 15-1.5-5, Physician Services and 410 IAC 15-1.6.5, Psychiatric Services, Hospital Licensure Rules. QA: claughlin 11/29/11	S 000		